

- 3 Griffiths M, Sanderson D, Penna LK. Cervical epithelial abnormalities among women with warts—no more common than among controls. *Int J Gynecol Cancer* 1992;2:49–51.
- 4 Hakama M, Pukkala E, Saastamoinen P. Selective screening: theory & practice based on high-risk groups for cervical cancer. *J Epidemiol Comm Health* 1979;33:257–61.
- 5 Austoker J, Duncan ID. Cervical screening in general practice. *BMJ* 1990;301:236–7.
- 6 Duncan ID (ed) 1992 (for National Co-ordinating Network). *Guidelines for clinical practice and programme management*. NHS Cervical Screening Programme. London.
- 7 McCormick JS. Cervical smears: a questionable practice? *Lancet* 1989;ii:207–209.

Moss replies:

I have read with interest correspondence from Dr. Malcolm Griffiths relating to our review of primary colposcopy.¹

This paper described an extension of retrospective research which was designed to begin to answer questions arising from the association and inter-relationship between cervical dyskaryosis and/or CIN and other concomitant sexually transmitted diseases. The original work was presented to the Working Party of the National Co-ordinating Network and was vigorously debated.

There are at least two valid reasons for considering future carefully prepared prospective primary colposcopy studies in collaboration with cytopathology. The first of these was acknowledged by the NCN Working Party:—“In young women HPV may be one of a multiplicity of sexually transmitted diseases present simultaneously and referral to a genito urinary medicine clinic should be considered.”² This seems in complete agreement with the conclusion made by Griffiths and colleagues in a study of 154 women with dyskaryotic cervical smears referred from colposcopy from “two distinct population groups”:—“We conclude that an abnormal cervical smear is frequently a marker of concomitant lower genital tract infection”.³

A second reason is that it is important to be aware of discrepancies between cytology and histology of more than 2 degrees of variance.⁴

In reply to Dr. Griffiths it must be asked does the paper by Giles *et al* support the case he has argued? Not everyone would think so. Dr Griffiths' letter appears to combine two separate references.^{5,6} Surely it is not valid to arbitrarily combine papers with a different methodology and with different outcomes and then construct a “combined conclusion”.

Giles clearly stated that the importance of small lesion size was unknown, not that small lesions were unimportant. By continuing primary colposcopy small numbers of cases of high grade CIN of variable lesion size are identified where the degree of variance with cytology is >2 degrees.

Further, current primary colposcopy has recently identified one case showing CIN III, where high grade colposcopic changes are present throughout all four quadrants and the abnormality extends onto the vaginal vault. Would anyone wish to leave such findings untreated? This process achieves earlier diagnosis and affords the opportunity to continue combined audit with cytopathology.

None of the authors of the review paper on primary colposcopy have any sceptical feelings regarding the value of cervical screening. On the contrary, applying this technology to new female attenders in GU

Medicine has allowed us to understand more about the variance (inter and intra observer variation) in cervical cytology and to develop a greater understanding of cytopathology, as well as to communicate and explain in a better way to our patients and to their partners.

Griffiths speculates that very few cases of cervical cancer diagnosed in the Doncaster area have ever been GUM attenders. The current Doncaster District confidential audit of cervical cancer deaths will identify any fatal cervical cancer cases who had attended genitourinary medicine clinics (1990 onwards). This, together with 14 years of follow-up audit in a town with a relatively stable population, may well confirm his views. Should he be proven to be correct then GU cytology here, combined with primary colposcopy might be judged to have served our population well.

This approach, and a historical review paper taken properly in context might also constitute an appeal for a compassionate and sensitive approach to colposcopy, with well informed patients in a comfortable, secure clinical environment. Few colposcopists would argue against this last concept.

For a current consensus UK viewpoint on the role of genito urinary colposcopy reference is made to a forthcoming Definitive Document from the National Co-ordinating Network.⁸

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- 1 Moss TR, Hawkswell J, Fogarty B, Dadswell C. The value of primary colposcopy in genitourinary medicine—a six year review. *Genitourin Med* 1994;70:191–5.
- 2 Duncan I, Editor, NHS Cervical Screening Programme, National Co-ordinating Network: Guidelines for Clinical Practice and Programme Management, National Co-ordinating Network, Oxford Regional Health Authority, March 1992.
- 3 Byrne MA, Turner MJ, Griffiths M, Taylor-Robinson D, Soutter WP. Evidence that patients presenting with dyskaryotic cervical smears should be screened for genital tract infections other than human papillomavirus infection. *European Journal of Obstetrics, Gynecol Reproductive Biology* 41(2):129–33, 1991 Sept 13.
- 4 Contreras-Melendez L, Herbert A, Millward-Sadler GH, *et al*. Assessment of the accuracy of cytology in women referred for colposcopy and biopsy: the results of a one year audit. *Cytopathology* 1992;3:267–74.
- 5 Giles JA, Hudson E, Crow J, *et al*. Colposcopic assessment of the accuracy of cervical cytology screening. *British Medical Journal* 1988; 296:1099–102.
- 6 Griffiths M, Sanderson D, Penna LK. Cervical epithelial abnormalities among women with warts—no more common than among controls. *International Journal Gynecol Cancer* 1992;2:49–51.
- 7 McIndoe WA, McLean MR, Jones RW, Mullins PR. The invasive potential of carcinoma in situ of the cervix. *Obstetrics & Gynecology* Vol 64 No 4 451–458.
- 8 The role of genitourinary medicine cytology and colposcopy in cervical screening: does the GU female population merit a different cytology/colposcopy strategy? National Co-ordinating Network Definitive Document. September 1994.

Genital herpes simplex virus type 1 in women

Wilson *et al*¹ reported an apparent increase in the prevalence of herpes simplex virus type 1 genital infection in women. We report a retrospective case note audit of patients presenting with clinical primary genital herpes, noting relative incidences of herpes simplex virus type 1 amongst male and female patients, and sexual practices.

Incidence of herpes genital infection

	Female	Male
Herpes simplex virus type 1	25 (67.6%)	9 (75%)
Herpes simplex virus type 2	12 (32.4%)	3 (25%)
Total	37	12

Ninety patients who had presented to the genitourinary medicine clinics at Durham and Bishop Auckland between April 1992 and April 1994 were identified using KC 60 data: code C10a (herpes simplex first attack). All were heterosexual and the group comprised 28 men and 62 women. All had genital swabs taken for viral culture, and these were all sent to the PHLS at Newcastle, where the isolates were typed using monoclonal antibodies conjugated to FITC. A result was documented in 89 case notes, of which 40 (44.9%) were negative. The majority of positive cultures were HSV 1 (see table).

Participation in orogenital sex was documented in 42 cases (although there was no differentiation between active or passive involvement). In the group with HSV 1, 23/32 (71.9%) had participated in oral sex, compared with the HSV 2 group in which 6/12 (50%) gave this history ($p = 0.296$). Details concerning orogenital contact were only present in 80 sets of notes. Presence or absence of cold sores in patient or partner, or a previous history of them, was poorly documented, being recorded in less than 50% of casenotes.

Evidence from Edinburgh and London suggests that herpes simplex virus type 1 does appear to have been increasing in incidence, although previously with a continuing predominance of HSV 2 in genital lesions.^{2,3} This may be related to orogenital contact—recent figures from the nationwide survey of sexual attitudes and lifestyles in the U.K.⁴ show that 75.2% of men and 69.2% of women have participated in oral sex at some time, with 55.6% of men and 49.5% of women reporting this practice in the last year.

This study only looked at cases of primary genital herpes, whereas Wilson *et al*¹ appear to have studied viral swabs taken from patients with primary or recurrent disease. If the incidence of HSV 1 is currently rising, it might be expected that the proportion of HSV 1 amongst cases of primary genital herpes may be increasing more noticeably.

Another clinic in the same region as our own has also reported a higher incidence of HSV 1 in women (in press).

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- 1 Wilson P, Cropper L, Sharp I. Apparent increase in the prevalence of herpes simplex virus type 1 genital infections among women. *Genitourin Med* 1994;70:228.
- 2 Smith IW, Peutherer JF, Robertson DHH. Virological studies in genital herpes. *Lancet* 1976;2:1089.
- 3 Barton IG, Kinghorn GR, Walker MJ, Al-Omer LS, Potter CW, Turner EB. Association of HSV I with cervical infection. *Lancet* 1981;2:1108.
- 4 Johnson AM, Wadsworth J, Wellings K, Field J. *Sexual Attitudes and Lifestyles*. Oxford, Blackwell 1994:159–163.